NCPSSM National Committee to Preserve Social Security and Medicare

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National Committee to Preserve Social Security and Medicare

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Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify this morning on the important issue of the impact of Medicare Advantage overpayments on the Medicare program. As President of the National Committee to Preserve Social Security and Medicare, I represent 4 million members and supporters who are vitally committed to the preservation of Social Security and Medicare – programs that are critical to our nation's retirement security.

The National Committee advocated in favor of adding a prescription drug benefit to the Medicare program for many years. We shared many seniors' expectations that a drug benefit would take the form of a simple expansion of the traditional Medicare program. Providing prescription drug coverage through traditional Medicare would have given beneficiaries a simple, standardized benefit, and allowed the federal government to leverage the purchasing power of millions of beneficiaries to lower drug prices.

As you know, this benefit structure is not what seniors received. The current Medicare Part D benefit is complicated, confusing and fragmented, and whatever competition exists between private plans has not been sufficient to slow the continued upward spiral of prescription drug prices. Because the drug benefit is provided entirely through private plans, it also represents the first major step toward the full privatization of the Medicare program.

The Medicare Modernization Act (MMA) is not only a mechanism for enacting a drug program that provides considerable financial benefit to the drug and insurance industries. For many, offering seniors prescription drug coverage for the first time was the "sweetener" intended to mask the taste of the medicine of privatization. As it has turned out, the drug benefit itself was a bitter pill for many seniors. But for the designers of the MMA, it was conceived as a way to smooth the passage of massive long-term changes leading to the privatization of the Medicare program. This was done despite the success and popularity of the traditional fee-for-service Medicare program, and despite the failure of past privatization efforts such as Medicare+Choice.

Mr. Chairman, the Medicare Modernization Act is a weapon aimed at the heart of the traditional Medicare program. It was designed to accomplish the goal expressed by former Speaker Newt Gingrich – to lure seniors voluntarily out of Medicare so that it would eventually wither on the vine. The overpayments to Medicare Advantage plans that you are exploring today represent one of the tools by which to achieve this end.

The National Committee believes that privatizing Medicare is just as likely to ultimately destroy the health care safety net for seniors as privatizing Social Security is to dismantle the foundation of retirees' income security. Through much hard work and education, groups such as ours have been able to temporarily halt the march of Social Security privatization. Unfortunately, we were not similarly successful with Medicare, so our efforts must be concentrated on reversing the most egregious provisions of the Medicare Modernization Act.

Privatization in the MMA takes a number of forms. First, there is the privatized nature of the drug benefit itself, which is only available through private plans and not through traditional Medicare. In addition, the MMA provided massive subsidies to the private sector, most of them in the form of the overpayments to private Medicare Advantage plans that the Committee is exploring today. Finally, we would note some of the lesser understood elements of privatization such as the 45% limit on federal funding, the privatization demonstration project known as the "comparative cost adjustment demonstration project" or "premium support", and the new provision means-testing the Medicare Part B program for the first time in the history of Medicare. All of these provisions collectively undermine the traditional Medicare program.

Private health plans, now called Medicare Advantage plans, were first allowed to participate in Medicare because some policymakers believed they could provide better services at a lower cost than traditional Medicare. In fact, because it was anticipated private plans would be so efficient, the government initially paid them 5 percent less for each beneficiary they enrolled than it would have cost to cover that same beneficiary in traditional Medicare.

In 25 years time, the powerful health insurance industry lobby has been extremely successful in turning this rationalization on its head. Instead of paying private plans *less* to reflect the efficiencies they argued would save the government money, Medicare now pays them significantly *more* than it would cost to cover the same beneficiaries through traditional fee-for-service Medicare. In fact, today the government pays an average of 12 percent more to cover a beneficiary in a private Medicare Advantage plan than it would cost to cover *that same beneficiary* in traditional Medicare. And some types of private plans can receive much larger payments. For example, Private Fee-For-Service plans are paid about 19 percent more than traditional Medicare and plans in some localities are paid 50 percent more than traditional Medicare. In simple dollar terms, Medicare pays about $1,000 more a year to cover a beneficiary in a private plan than it would cost to provide care to that same beneficiary under traditional Medicare.

All beneficiaries, whether they enroll in a private plan or not, subsidize payments to private companies by paying higher Part B premiums. Today, these premiums are almost $50 per year higher per couple than they should be because of overpayments to private plans. This number will clearly continue to grow exponentially in future years. These increases are in addition to the record-setting increases in Part B premiums beneficiaries have already experienced – and which are expected to continue – as a result of increases in the cost of health care.

In addition to adding costs for individual beneficiaries, overpayments to Medicare Advantage plans result in higher costs to the federal government. Medicare's Actuaries estimate that eliminating these overpayments would add two years of solvency to Medicare's hospital insurance trust fund. These additional costs are absorbed by the Medicare program at a time when health care costs are growing dramatically, both for the federal government and for beneficiaries. In fact, President Bush and some others have insisted that the federal government cannot afford to continue supporting entitlement programs such as Medicare over the long-term. President Bush has included deep cuts to Medicare in his past two budgets, and many of his supporters in Congress have pushed to include sizeable Medicare cuts in the budget process this year. In addition, the automatic triggering mechanism included in the Medicare Modernization Act of 2003 has initiated a process designed to result in significant cuts in Medicare as early as 2009.

Many of the causes of increased Medicare costs are difficult to tackle – they reflect the same factors that have resulted in skyrocketing increases in health care costs for the under-65 population that have proven so intractable. Many experts continue to struggle with ways to solve this problem.

But I can point out one cost reduction that is obvious and can be addressed by this Congress quite simply – the overpayments to Medicare Advantage plans. Overpaying private plans adds to the cost of the Medicare program for both beneficiaries and for taxpayers. Unlike the more complex challenges of curbing the overall growth of health care, it is the one cost that is easiest to control. Congress created the expanded subsidies in the Medicare Modernization Act. Congress can vote to eliminate them.

The National Committee believes that Medicare should equalize payments between the traditional program and private plans. We support the Medicare Payment Advisory Commission's (MedPAC) recommendation of financial neutrality between payments in the traditional fee-for-service program and payments to private plans. Equalized payments would level the playing field and remove private plans' unfair advantage in attracting beneficiaries.

Continuing to overpay private insurance companies to provide services that could be more affordably and efficiently provided by the traditional Medicare program is unconscionable. According to the Congressional Budget Office (CBO), leveling the playing field could save taxpayers $149 billion over the next ten years. Congress should remove these unwarranted subsidies and use a portion of the savings to improve benefits for low-income Medicare beneficiaries.

I cannot overstate the damage these Medicare Advantage overpayments will cause to the traditional Medicare program if they are not eliminated. Medicare Advantage plans tend to attract healthier seniors because of their benefit structures. As more of these seniors are lured out of traditional Medicare, overpayments to the private plans will continue to grow dramatically. That will result in even higher costs for taxpayers, and increasing premiums paid by those remaining in the traditional program. Over time, this cycle of higher payments and growing costs will simply become unaffordable – for both taxpayers and beneficiaries.

Ultimately, this cycle will shatter the risk pool that makes Medicare work. Increasing numbers of healthier seniors will abandon traditional Medicare for the private sector, leaving the frailest and most vulnerable to pay the price not only for their own care, but also for the growing subsidies to the private plans. Over time, political support for the program will shift. Today's social insurance concept of shared risk will be replaced by the ownership society's concept of individual risk. And hand-in-hand with individual risk will come an individualized payment system such as vouchers.

Vouchers save money for healthy beneficiaries and shift the burden of health care to the frailest and sickest among us. They shift risk from shared pools to individuals. And they provide no containment for health care costs. Eventually we will find ourselves in a world much like that before Medicare was created, and health care will be unaffordable for the average senior. *At a time when our nation is struggling with how to create affordable, universal health care coverage for our workers and their families, it is simply incomprehensible to me why we would destroy the one affordable, universal health care system that already exists in Medicare.*

You will hear arguments that the Medicare Advantage overpayments are necessary to provide improved health care services to groups such as beneficiaries with multiple, chronic conditions, minorities, those living in rural areas or the poor. Of course, we don't really know whether Medicare Advantage plans actually provide any significant benefits to these groups because of the lack of reporting and claims of proprietary information. What we do know is that the numbers the insurance industry is using about the impact of Medicare Advantage plans on these vulnerable groups are misleading. We also know that private industry is insisting on being overpaid to provide these services – clear proof that this is not the most efficient way to deliver benefits.

If Congress believes higher payments are needed to improve the health of beneficiaries in these groups, it would be much simpler and less expensive to increase resources targeted to the groups directly, by expanding low-income programs. Instead of giving private plans extra money and simply hoping some if it finds its way to these vulnerable populations, Congress should improve the Medicare Savings Programs or the low-income prescription drug subsidy.

Mr. Chairman, the vast majority of Medicare beneficiaries remain in the traditional program. You may not hear their voices as loudly as you do the insurance industry's but believe me when I tell you they will be seriously hurt if Congress does not eliminate

Medicare Advantage subsidies immediately. The decisions you make this year will impact the Medicare program for decades to come.

BACKGROUND

Overpayments to private plans increase Part B premiums for all Medicare beneficiaries. The Medicare program finances overpayments to private plans with money collected by general revenues and beneficiary premiums. MedPAC has estimated that every Medicare beneficiary pays $24 a year in higher Part B premiums just to fund excess payments to private plans. In other words, the majority of Medicare beneficiaries—the 81 percent of beneficiaries choosing to remain in traditional Medicare—are paying to subsidize the private plans that provide benefits to the remaining 19 percent of beneficiaries. Because subsidies are projected to continue rising, all Medicare beneficiaries can expect to pay dramatically higher premiums in the future, and can expect increasing portions of those premiums to be diverted to private plan subsidies.

Eliminating overpayments would save billions of dollars and improve Medicare's financial outlook. The Congressional Budget Office (CBO) projects that Medicare will pay $75 billion to private plans in 2007 and $1.31 trillion to private plans over the next ten years. Federal spending on Medicare Advantage plans will continue to grow as more beneficiaries are lured out of traditional Medicare as a result of the excessive payments made to private plans. According to CBO, paying private plans at the same rate as traditional Medicare would save $54 billion over the next five years and $149 billion over the next ten years. Not only would eliminating these large overpayments save billions of dollars, it would also add two years of solvency to Medicare's hospital insurance trust fund.

Overpayments are used to improve insurance industry profits and are not completely passed along to beneficiaries. When Congress approved the system which overpays private plans, policymakers intended that the excess payments be returned to beneficiaries in the form of additional benefits or reduced cost-sharing. It is not at all clear to what extent this is occurring. Private plans are subject to few public reporting requirements, so it has been extremely difficult to determine what percentage of the overpayments has inflated the profit margins of the private insurance companies offering the plans, or has been used for marketing, rather than being returned to beneficiaries. In the case of Private Fee-For-Service plans, MedPAC found that only about half of the excess payment is used to deliver extra benefits for enrollees. The remainder of the payment is used to finance the administrative costs, marketing, and profits of private plans.

Overpayments are driving unscrupulous agents and private plans to use aggressive sales tactics and misrepresentations to sell their products to beneficiaries. A recent survey of state insurance departments found that 39 of 43 states had received complaints about misrepresentations and inappropriate marketing practices of Medicare Advantage plans. In most cases, these practices led to Medicare beneficiaries enrolling in a private

plan without adequate understanding of the plan or their ability to stay in traditional Medicare. The inflated payments to private plans allow them to offer exceedingly large commissions to agents who enroll beneficiaries into Medicare Advantage plans, regardless of whether the plan meets their needs. To receive their commissions, some insurance agents have engaged in fraudulent activities including: forging signatures on enrollment documents; mass enrollments and door-to-door sales at senior centers, nursing homes, or assisted living facilities; and enrolling beneficiaries with dementia into inappropriate plans. Removing overpayments, increasing oversight and regulation, and limiting large commissions would help to prevent beneficiaries from falling victim to unethical and illegal sales tactics.

Eliminating overpayments would not adversely affect low-income and minority beneficiaries. Contrary to insurance industry claims, private plans do not attract a disproportionate number of low-income and minority beneficiaries. A recent analysis by the Center on Budget and Policy Priorities found that these Medicare beneficiaries are far more likely to receive supplemental coverage through Medicaid than to be enrolled in Medicare Advantage. The Center found that nearly half (48 percent) of all Medicare beneficiaries with incomes under $10,000 receive Medicaid, compared to only 10 percent who are enrolled in private plans. Similarly, they found that most Asian American Medicare beneficiaries (58 percent), and a plurality of African American (30 percent) and Hispanic beneficiaries (34 percent) receive Medicaid, compared to the 14 percent of Asian Americans, 13 percent of African Americans, and 25 percent of Hispanics enrolled in private plans. If Congress believes higher payments are needed to improve the health of beneficiaries in these groups, it would be much simpler and less expensive to increase federal resources targeted to these groups directly by expanding low-income programs. Instead of giving private plans extra money and simply hoping some of the funds find their way to these vulnerable populations, Congress could improve the Medicare Savings Programs or the low-income prescription drug subsidy.

Eliminating overpayments would not adversely affect beneficiaries living in rural areas or inner cities. Proponents of private plans have argued that beneficiaries living in areas that are difficult or expensive to serve need an expanded and overpaid Medicare Advantage program to continue receiving services. In fact, in many rural and low-income inner cities exactly the opposite is true: the expansion of bloated private plans accelerates the deterioration of traditional fee-for-service providers, and undermines the ability of hospitals and other providers to continue operating. Medicare payments to hospitals, doctors and other providers who care for beneficiaries in traditional Medicare today are partly based on geographic differences in the cost of providing health care. If Congress believes even higher payments are necessary to ensure beneficiaries in some parts of the country receive adequate services, it would be much more efficient to modify Medicare's geographic cost adjustment or provide additional payments to areas where Medicare providers are particularly scarce or have costlier expenses. This way plans in counties with greater need could receive higher payments without harming the traditional Medicare system in those areas or the beneficiaries who chose to remain in it.

Despite receiving inflated payments, Medicare Advantage plans can provide inferior health coverage compared to traditional Medicare. Private plans do not necessarily provide benefits that are fully equivalent to traditional Medicare. They are required to cover everything that Medicare covers, but they do not have to cover every benefit in the same way. For example, private plans may create financial barriers to care by imposing higher cost-sharing requirements for benefits such as home health services, hospitalization, skilled nursing facilities, inpatient mental health services, and durable medical equipment that protect the sickest and most vulnerable beneficiaries. In many cases, beneficiaries are lured into the private plans based on improved coverage of relatively inexpensive services such as expanded dental or vision care, only to discover after it is too late that their plans shift significantly more of the higher costs of major illnesses onto their shoulders. Preventing private plans from imposing greater cost-sharing requirements than traditional Medicare would better protect beneficiaries from high out-of-pocket costs.

Failure to rein in overpayments to private plans will lead to the privatization of Medicare. Continuing to dole out excessive and unwarranted payments to private plans will undermine traditional Medicare. Private plans use these overpayments to offer additional benefits like gym memberships that attract healthier enrollees. They can also discourage sicker beneficiaries from joining their plan by charging higher cost-sharing for hospitalization and home health benefits. Eventually, Medicare's risk pool will be shattered as those with greater health care needs remain in the traditional program, paying increased taxes and higher Part B premiums to subsidize overpayments to private plans. Eliminating overpayments would allow traditional Medicare to provide efficient and affordable health coverage to all beneficiaries for generations to come.

NATIONAL COMMITTEE POSITION

Medicare should equalize payments between the traditional program and private plans. The nonpartisan Medicare Payment Advisory Commission (MedPAC) has recommended that Medicare pay the same amount regardless of whether a beneficiary enrolls in traditional Medicare or Medicare Advantage. Instead of being paid up to 50 percent more than traditional Medicare, private plans should be paid at a rate equal to the costs of traditional Medicare in every part of country. Equalized payments would level the playing field and remove private plan's unfair advantage in attracting beneficiaries.

Savings from eliminating overpayments should be used to help low-income Medicare beneficiaries. The most cost-effective and efficient way to help low-income and minority beneficiaries is to use a portion of the savings collected from eliminating Medicare Advantage overpayments to strengthen the Medicare Savings Programs and improve Medicare Part D's Low-Income Subsidy program.

Private plans should be prohibited from charging higher out-of-pocket costs for benefits than traditional Medicare. It is particularly egregious for private plans to receive excess payments while providing lesser coverage. To better protect Medicare

Advantage beneficiaries from high out-of-pocket costs, policymakers should prevent private plans from imposing higher cost-sharing requirements than traditional Medicare.

Traditional Medicare is an option that must be preserved. The vast majority (81 percent) of Medicare beneficiaries choose to remain in the traditional program. The special treatment of Medicare Advantage plans allows them to receive higher payments than traditional Medicare and allows them to impose higher cost-sharing on beneficiaries. This treatment is particularly unwarranted because there is no available data to suggest that private health plans deliver any better health outcomes than traditional Medicare. If Medicare continues to fund large overpayments to private plans, the program will face growing fiscal pressure to cut benefits or increase beneficiary cost-sharing.

Thank you for inviting me to testify today, Mr. Chairman. I look forward to working with you and the other members of this Committee to reverse the privatization of Medicare that has been imposed through the Medicare Modernization Act. Eliminating overpayments to Medicare Advantage Plans is the first important step toward achieving that goal.